

Idaho Medical Home Collaborative

Preliminary Report: Survey & Self-Reported Findings

TRANSFORMED, LLC

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Executive Summary

Created By Governor Otter in 2010 by Executive Order 2010-10 and overseen by the Idaho Department of Insurance (DOI), the Idaho Medical Home Collaborative (IMHC) is a collaboration of primary care physicians, private health insurers, healthcare organizations and Idaho Medicaid. They are charged with making recommendations to the governor on the development, promotion, and implementation of a patient-centered medical home (PCMH) model of care statewide- including PCMH definition, provider qualifications and standards, payment methodologies, consumer and provider engagement, care coordination and case management guidelines, health data exchange and evaluation measures, including cost- and quality-based outcomes measures.

Following an application process and notification of practice acceptance in October of 2012, a pilot project commenced in January of 2013 to assess methods and the impact of PCMH implementation. A multi-payer project including Idaho Medicaid, Blue Cross of Idaho, Pacific Source and Regence Blue Shield, the project established baseline requirements and provided both financial and technical support to 36 practices over the course of the next year. TransformMED, LLC (a wholly owned subsidiary of the American Academy of Family Physicians) was selected under a competitive-bid process to conduct a summative analysis of the pilot project. This final report provides an overview of that evaluation, including the key questions answered, data sources, analytic variables and claims-based evaluation outcomes.

This preliminary report discusses findings associated with the self-reported and survey based data collected. As such, it has inherent limitations associated with the biases of self-reported data. However, after a thorough review of the data and the conduct of its analysis, I am comfortable stating that this report provides a fair and accurate description of the pilot project results within these areas. I have provided a list of future project design implications, based upon my findings within this dataset. These recommendations are driven by the results within the IMHC project and my interpretation of those results against the national backdrop of healthcare reform and primary care practice transformation efforts. This preliminary report will be added to an additional Preliminary Report of Claims Based Data Outcomes, still under development, and joined by a final Executive Summary Document upon the conclusion of the analyses.

Russell Kohl, MD, FAAFP
Chief Medical Officer
TransformMED, LLC

Future Project Design Implications

- **Leadership Development-** Future projects should include efforts to provide realistic, hands-on training to practice-level leadership about how to motivate and lead a team undergoing transformation.
- **Pay-For-Quality-** Future projects should leverage a panel of “all or none” quality measure components with payment incentives based upon quarterly performance against benchmark, not peers
- **Practice Transformation Support-** Practices with low performance in clinical quality measures should first undergo change readiness evaluation (and focused intervention) prior to beginning PCMH focused efforts
- **Engage Public in Portal Use-** A patient education campaign that increases demand for portal usage will more effectively drive implementation than Meaningful Use support
- **Develop HIE Infrastructure-** HIE must evolve to facilitate useful interfacility transfer of data before practices will effectively participate.
- **Focus on Work-Life Balance Impact of Efforts-** More providers will likely respond to efforts that are believed to improve work-life balance than those that increase income
- **Build Demand Before Launching Tools-** Current staff and providers do not perceive a need for additional resources, so any future deployments must begin with establishing a need.
- **Incentivize Increasing Provider / Staff Wages-**
- **No Payer Program Evaluated Was Superior At Achieving PCMH Transformation-** As a result, efforts at developing idealized incentives should continue to be tested
- **Use of the PCMH-A or PCDC Tool Should Not Be Encouraged As A Manner To Improve Clinical Quality-** Alternative outcomes remain under review, but performance and improvement on these measures do not predict quality outcomes nor their changes.
- **Convene Regional Collaboratives Around Community Adoption of Evidence Based Guidelines for Select Chronic Diseases-** Peer pressure and transparent sharing of best practices in achieving improved healthcare outcomes must become the norm.

Change Readiness Results / Findings

Description of Survey

Developed and utilized by TransformMED over the past 7 years, the change readiness survey is a validated tool that assesses skills and aptitudes of both staff and leadership around the domains of Leadership, Teamwork, Change Communication, Work Satisfaction and Ability to Influence Others. The results are compared against historical results from practices participating with TransformMED projects in the past, allowing for the determination of relative strengths and weaknesses. This was accomplished by staff in 5 pilot project practices. The aggregated results are reported in Appendix A. Since this survey was accomplished at the end of the project, it is not possible to comment on how it has changed and whether these results are a result of the work accomplished during the pilot project. However, if we base this consideration on the assumption that practices within the pilot project began from national average capabilities of Change Readiness, it would suggest that the interventions of the pilot project had significant positive effects on the practices' capacity for future change.

Staff Results

Staff members completing the survey scored exceptionally high in comprehensive change readiness against peer comparators within the TransformMED project database. Compared to a database average around the 60% range, staff participating in the IMHC pilot project scored within the 70-75% range. This indicates a high likelihood of success in efforts at practice transformation. Areas of particular strength included work satisfaction, influencing others and change communication. Ironically, these key factors of effective teamwork were rated higher than the staff's actual self-perception of teamwork. The lowest area of results were the domains of teamwork and leadership. This would suggest that staff feel a greater involvement and ownership within the change process than they perceive leadership having or supporting. It is crucial to not focus on this finding as a shortcoming, due to the still quite high results.

Leadership Results

Personnel identified as Practice Leadership scored quite similar, though slightly above, peers within the TransformMED database. While they likewise stressed Change Communication and Work Satisfaction, they scored at the median for Influencing Others. While their leadership score was noted to be equal to the perception of the staff, this is an unusual finding. Typically, Leadership score themselves far higher than staff do. This would suggest an enlightened Leadership perspective that is closely aligned with staff and very concerned about promoting an environment of Teamwork and concerned about their Change Communication capabilities.

Correlation With Other Data Points

Due to the relatively small number of practices responding, definitive statistical correlation cannot be achieved. However, interesting trends can be observed within these findings. It is noted that, despite high scores around change readiness, there was little to no change in either the PCDC or PCMH-A scores for respondent practices between the beginning and end of the project. Likewise, the responding practices were largely dispersed across the range of PCMH-A and PCDC scores. What makes this particularly interesting is the observation that these practices had near universal improvement in their self-reported quality scores. While I must stress that this is not statistically definitive, a trend in the pilot project towards high change readiness scores being associated with clinical measure improvement, but no significant effect on measures of "PCMH-ness," has potentially large implications for future efforts within the state.

Implications for Future Projects

The high scores and close correlation of leadership and staff respondents bodes well for future efforts at practice transformation within the responding practices. There appears to be a high level of joint mission/ vision, but some weakness around communicating that from leadership to staff. These results would suggest that future efforts at changing behavior should provide additional resources or training to practice leadership about how to develop and share their “big picture” outcomes for transformation work and clarifying how each team member contributes to that mission/ vision.

The finding around their lack of PCMH-A and PCDC score changes correlating with clinical quality scores is particularly interesting. Previous work at TransforMED has suggested that a focus upon quality improvement structure and skills for front-line staff has a tremendous impact- by developing the infrastructure through which the philosophical underpinnings of PCMH can be applied. These results would suggest that future efforts should establish quality measurement goals for practices, while focusing on practice-level change management capacity only as a means to achieve these goals. Finally, the Change Readiness results suggest that the PCMH-A and PCDC tools have little predictive value around a practice’s change readiness/management abilities.

Provider Satisfaction Results / Findings

Description of Survey

Developed and utilized by TransformMED over the past 7 years, this provider satisfaction survey was deployed to all providers participating in the pilot project practices. Completed surveys were received from 48 providers, representing 15 practices, and were fairly evenly split between physicians and physician extender providers. The aggregated results are reported in Appendix B. Since this survey was accomplished at the end of the project, it is not possible to comment on how it has changed and whether these results are a result of the work accomplished during the pilot project. However, if we base this consideration on the assumption that practices within the pilot project began from national average for Provider Satisfaction, it would suggest that the interventions of the pilot project had significant positive effects.

NP/PA vs Physician Results

The results were initially parsed by provider type, but it was noted that minimal differences existed in their responses. A Pearson correlation confirmed this with a value of .83 ($p < .05$). This would suggest a similar experience for both physicians and NP/PA's participating within the pilot project.

Significant Results

- ~90% of respondents had a non-negative response about their perceptions of the availability of resources, which is roughly equal to the providers that look forward to coming to work each day
- ~84% of respondents feel that they are able to practice medicine as they envisioned at the end of their training
- 16% feel that they are not paid fairly for the work that they do
- ~18 % of respondents feel that their current work-life balance is not what they had envisioned
- ~88% had a non-negative response about adequate clinical and clerical support
- When asked if the benefits of implementing an EHR has outweighed the challenges, 50% agreed, 16% were neutral and 33% disagreed.
- When asked if using an EHR had improved their ability to provide high quality care to their patients, 44% agreed, 27% were neutral and 29% disagreed.

Correlation With Other Data Points

Findings within the Provider Satisfaction Survey are quite similar to those within the Staff Satisfaction survey. While this may not seem a significant point to make, it is actually quite important to future efforts within the state. The relative closeness of responses from Physicians, NP/PA's, and Staff suggest that the experience of care provision within pilot project practices transcends role within the practice. This is highly suggestive of a strong culture of team-based care within the practices. Whether this existed prior to the intervention is impossible to comment on definitively, but it does offer a glimpse into a potential strength that is highly associated with future transformation success.

EHR Implications for Future Projects

While EHR implementation was widespread across the project, the results of the provider satisfaction survey suggest that there remains only moderate buy-in. A majority of respondents did not see the benefits of HER adoption

outweighing the challenges, which could be the result of either excess challenges or limited benefit. Discussion with practices has suggested that the answer is actually both. Due to rural locale with limited connectivity options, limited technical support and no significant interoperability or health information exchange, most practices have failed to see a benefit from implementation. The relative immaturity of registry reporting and the limited linkage of this to alternative payment models also limits practice motivation and enthusiasm. Future efforts at boosting EHR use should focus on the development of robust data transfer between facilities and providers, as well as efforts to drive patient demand for portal and alternative methods of communication and access.

Provider Satisfaction Implications For Future Projects

Providers in the pilot project were significantly more satisfied than the national average and reported higher rates of clinical and clerical support than national peers. This is similar to the staff satisfaction findings and would suggest that efforts focusing on the deployment of additional tools or resources are not likely to generate significant interest in the provider population. While lower than staff, 16% of providers felt that they were not paid fairly for their work (with no difference between physician and NP/PA respondents) suggesting a potential motivating role for additional income sources. Since almost 1 in 5 providers are not pleased with the work-life balance, future transformation efforts should emphasize the impact that interventions can have on factors that directly affect this area- such as work after clinic, etc.

Staff Satisfaction Results / Findings

Description of Survey

The staff satisfaction survey was deployed to all non-provider staff in the pilot project practices. Completed surveys were received from 155 persons and represented results from 21 different practices. The comprehensive results are included in Appendix C. Since this survey was accomplished at the end of the project, it is not possible to comment on how it has changed and whether these results are a result of the work accomplished during the pilot project.

However, if we base this consideration on the assumption that practices within the pilot project began from national average for Medical Staff Satisfaction, it would suggest that the interventions of the pilot project had significant positive effects.

Significant Results

- ~93% of respondents had a non-negative response about their perceptions of the availability of resources, which is roughly equal to the staff that look forward to coming to work each day and that feel they work with a supportive team
- ~17% of staff see no opportunities for growth within their job
- Roughly 26% of staff feel that they are not paid fairly for the work that they do
- ~86% of staff feel that they can “tell my boss what I think.”
- Staff are divided about whether their ideas and suggestions are being considered as part of the practice’s transformation to a PCMH, with 13% responding negatively, 29% neutral and 58% positively.

Implications for Future Projects

The remarkably positive responses about resource availability are relatively unique to this project and far above TransforMED peers. As a guide to future projects, the survey results would suggest that efforts by payers to provide additional resources in the form of tools/ reports, etc are likely to meet with limited success. If data visibility is limited at this time (as suggested by the Provider Satisfaction Surveys), the staff do not currently perceive this as a need. As a result of the lack of recognition of need for additional tools or data and the 1 in 4 staff members who perceived themselves to be unfairly paid, it is likely that future efforts at practice transformation should consider the provision of additional funds that could be directed towards staff salaries. Of the responding practices, only 2 participated in the Regence pilot that required practices to expend their additional funds on a dedicated care manager within the practice. Interestingly, these practices were split on the questions of resource availability and paid fairly, failing to distinguish themselves from other practices that did not have such restrictions. While there are obvious limitations based on the extremely small sample size, these findings would suggest that such restrictions did not have a direct impact on staff satisfaction.

Self-Reported Quality Measures Findings

Description of Survey

Clinical Quality Measures

Each practice was required to report on one of the following areas for clinical reporting.

Diabetes Measures:

Hemoglobin A1c Testing

Diabetes hemoglobin A1c not under control

Hypertension Measures:

Controlling high blood pressure

Hypertension: blood pressure measurement

Depression Measures:

Anti-depressant medication management

Clinic/Practice program screening for depression

Asthma Measures:

Asthma assessment (% of asthmatic patients with assessment)

Asthma pharmacologic therapy (% of asthmatics prescribed long-term control –medication)

Management plan for people with asthma (% of asthmatics with documented care plan)

Preventive Quality Measures

All practices were required to report on two of the following preventive quality measures:

- Weight assessment counseling for children and adolescents
- Well-child visits in the third, fifth and sixth years of life
- Annual risky behavior assessment or counseling from age 12 to 18
- Tobacco use assessment
- Tobacco cessation intervention
- Adult weight screening and follow-up

Significant Results

- 6 out of the 7 practices reporting BP Measurement achieved improvement
- Though popular as a measure, only 4 of the 18 practices reporting tobacco use documentation achieved improvement
- 26 practices reported their A1c testing rate with an average of 72.96%. During the course of the project, 18 practices improved for an average end result of 79.73%
- 29 practices reported their A1c non-control rates with an average of 23% of diabetic patients with an A1c > 9, declining to 19% by project end.
- No change in % of patients seeing their PCP was reported, with results remaining stable at 68%

- An inadequate number of responses were provided to assess impact of the project on either asthma or pediatric well-child visits (although the well-visits will be readdressed using claims data)
- While improvements may have been seen, practices typically did not move from their quartile for quality performance when compared with the remainder of the project
- Use of smaller EHR vendors was associated with lower quality scores
- Practice location within Region 3 was associated with higher reported quality measures

Correlation With Other Data Points

The finding that use of eClinicalworks or SuccessEHR was associated with lower performance on self-reported quality measures is potentially the result of a confounding influence. While it is possible that these smaller software programs lack the robust support required for achieving or documenting success, it is more likely a proxy measure for a smaller practice with more limited constraints. This is particularly important when tied back to the staff and provider satisfaction survey results around limited perception of need for additional resources. As such, it is felt that the EMR selection is more likely a spurious correlation or marker for a separate factor than an actual deciding factor.

Implications for Future Projects

Process measures such as recording BP and obtaining A1c testing were widely improved throughout the project. This would suggest that efforts focused on establishing workflows may have been an effective part of the intervention and should be replicated in future projects. Also discovered in discussions with involved practices is a provider sense of “data isolation,” where they are unable to compare results against peers to establish a point of reference for their performance. The establishment of benchmark quality levels and potentially public reporting of quality performance could be useful to overcome this sense of “data-isolation.” In addition, the convening of multi-regional provider collaboratives charged with developing/adopting community based standards of care around evidence based protocols may facilitate further improvements.

PCMH Evaluation Tools Findings

Description of Surveys

Patient-Centered Medical Home Assessment (PCMH-A)

Developed by the Safety Net Medical Home Initiative and based upon the Change Concepts for Practice Transformation framework, the PCMH-A was required to be completed by each practice within the first month of pilot participation and every six months thereafter. The PCMH-A helped identify areas of strength and weakness that each clinic worked on during practice transformation, with results reported in the following domains: Laying the Foundation: Engaged Leadership and Quality Improvement Strategy, Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships, Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions, and Reducing Barriers to Care: Enhanced Access and Care Coordination.

Primary Care Development Corporation (PCDC) Assessment

The Primary Care Development Corporation (PCDC) Self-Assessment tool was completed within 6 months of the beginning of pilot participation and quarterly thereafter. The assessment maps to the National Committee for Quality Assurance (NCQA) factors, which tracks progress toward meeting specific NCQA standards associated with recognition. Upon NCQA recognition, the clinic site was no longer be required to complete the PCDC assessments.

Significant Results

- The average PCMH-A score in the project was 62.94 with an average decrease in scores of 1.24 observed.
- The average PCDC score in the project was 63.9 with an average decrease of 7.5 observed.
- The correlation between a practice's total PCMH-A score and PCDC Score was 0.71
- The correlation between a practice's change in PCMH-A score and PCDC score over the life of the project was 0.81
- No correlation could be found between PCMH-A score and either performance or improvement on self-reported quality measures
- No correlation could be found between PCDC score and either performance or improvement on self-reported quality measures
- A natural stratification of results with threshold effects seem to occur at PCDC score of 55 and 75
- PCMH-A scores maintained a relatively even distribution and did not appear to demonstrate threshold effects.
- Low performance within a domain was associated with the greatest amount of domain improvement at conclusion of the project
- No difference amongst payers was noted for either PCMH-A score (or change) or PCDC score (or change)

Correlation With Other Data Points

Very little correlation could be identified with the practices' results from their PCMH-A and PCDC. There were no notable differences observed between regions or practice staffing ratios. Medical residencies tended to score higher, as did those with NCQA recognition, but achieved virtually no change in scores during the course of the project and largely failed to improve performance around self-reported quality measures.

Implications for Future Projects

The high level of correlation between both the absolute results and the relative change over the course of the project between the PCMH-A and PCDC results would suggest limited utility in performing both surveys as part of future projects. The lack of correlation between performance on these surveys and the self-reported quality measures presents a somewhat troubling finding. It does not appear that using these tools to guide transformation within the practice is an effective manner in which to improve their objective measures of quality. The potentially more far-reaching implications of improved measures “PCMH-ness” on cost and utilization will be reviewed in our claims-derived report. Based solely upon the survey and self-reported quality measures aspects of our analysis, we can not identify any impact of these surveys on the performance of the practices. Likewise there doesn’t appear to be a differential effect on the scores associated with any particular payer program- suggesting equivalency in their methods to promote PCMH implementation.

Appendix A: Aggregated Change Readiness Survey Results



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CRS 2.0 Project Report - State of Idaho, Dec. 2014 (SIDAHO)

Staff

Group	Leadership	Teamwork	Change Communication	Work Satisfaction	Influencing Others	Total
Advanced Family Medicine	31	-	-	-	-	31
Community Health Clinics Inc. FQHC	20	20	19	14	9	82
Family First Medical Center	32	32	29	22	14	129
Family Health Services Corp	28	28	26	19	13	114
Health West	-	-	-	-	-	-
Ironwood Family Practice	17	13	19	12	9	70
Sandpoint Pediatrics	-	-	-	-	-	-
St Mary's Clinic	-	-	-	-	-	-
Valley Medical Center	-	-	-	-	-	-
All Staff in Project	26	26	24	18	12	106
Percent Score	72%	72%	75%	75%	75%	74%
All CRS 2.0 Staff	22	21	20	14	9	86
Percent Score	61%	58%	63%	58%	56%	60%
Total Possible	36	36	32	24	16	144

Areas of Strength**: Change Communication

Areas for Emphasis**: Teamwork, Work Satisfaction

**Note: Areas of Strength = 1 highest Avg. Score % modules; Areas for Emphasis = 2 lowest Avg. Score % modules.

Leadership

Group	Leadership	Teamwork	Change Communication	Work Satisfaction	Influencing Others	Total
Advanced Family Medicine	27	22	22	18	12	101
Community Health Clinics Inc. FQHC	26	24	23	20	12	105
Family First Medical Center	31	29	24	20	13	117
Family Health Services Corp	23	20	19	16	10	88
Health West	27	26	28	20	12	113
Ironwood Family Practice	-	-	-	-	-	-

Sandpoint Pediatrics	10	11	16	17	11	65
St Mary's Clinic	24	22	21	14	9	90
Valley Medical Center	24	23	20	18	10	95
All Lead In Project	26	24	22	17	11	100
Percent Score	72%	67%	69%	71%	69%	69%
All CRS 2.0 Lead	25	23	21	16	11	96
Percent Score	69%	64%	66%	67%	69%	67%
Total Possible	36	36	32	24	16	144

Areas of Strength**: Leadership

Areas for Emphasis**: Teamwork, Change Communication

**Note: Areas of Strength = 1 highest Avg. Score % modules; Areas for Emphasis = 2 lowest Avg. Score % modules.

Combined

Group	Leadership	Teamwork	Change Communication	Work Satisfaction	Influencing Others	Total
Advanced Family Medicine	29	22	22	18	12	103
Community Health Clinics Inc. FQHC	23	22	21	17	10	93
Family First Medical Center	31	30	26	21	13	121
Family Health Services Corp	25	24	22	17	11	99
Health West	27	26	28	20	12	113
Ironwood Family Practice	17	13	19	12	9	70
Sandpoint Pediatrics	10	11	16	17	11	65
St Mary's Clinic	24	22	21	14	9	90
Valley Medical Center	24	23	20	18	10	95
All Combined In Project	26	25	23	17	11	102
Percent Score	72%	69%	72%	71%	69%	71%
All CRS 2.0 Combined	23	22	20	15	10	90
Percent Score	64%	61%	63%	63%	63%	63%
Total Possible	36	36	32	24	16	144

Areas of Strength**: Leadership

Areas for Emphasis**: Teamwork, Influencing Others

**Note: Areas of Strength = 1 highest Avg. Score % modules; Areas for Emphasis = 2 lowest Avg. Score % modules.

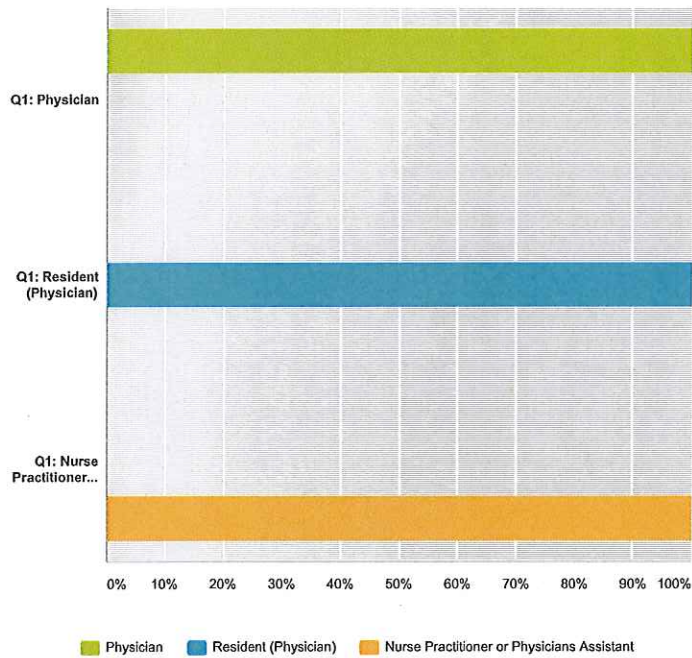
Appendix B: Aggregated Provider Satisfaction Survey Results

Individually Identifying Respondent Information Omitted

Idaho Provider Satisfaction Survey, December 2014

Q1 Please indicate your role with the practice.

Answered: 48 Skipped: 0

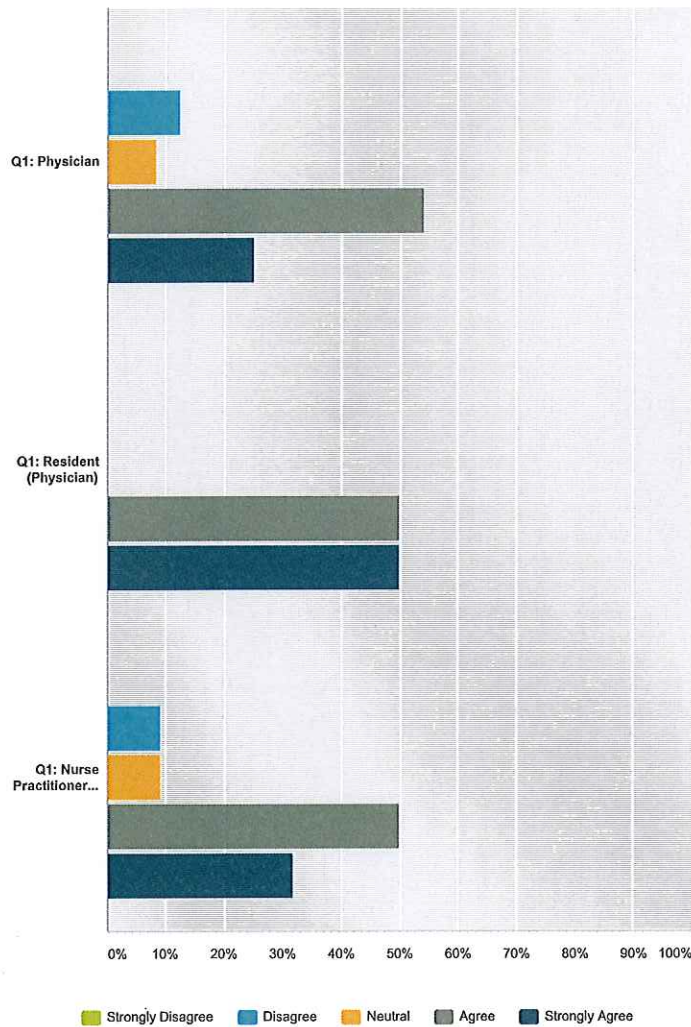


	Physician	Resident (Physician)	Nurse Practitioner or Physicians Assistant	Total
Q1: Physician	100.00% 24	0.00% 0	0.00% 0	24
Q1: Resident (Physician)	0.00% 0	100.00% 2	0.00% 0	2
Q1: Nurse Practitioner or Physicians Assistant	0.00% 0	0.00% 0	100.00% 22	22
Total Respondents	24	2	22	48

Idaho Provider Satisfaction Survey, December 2014

Q3 I have the tools and resources needed to perform my job.

Answered: 48 Skipped: 0

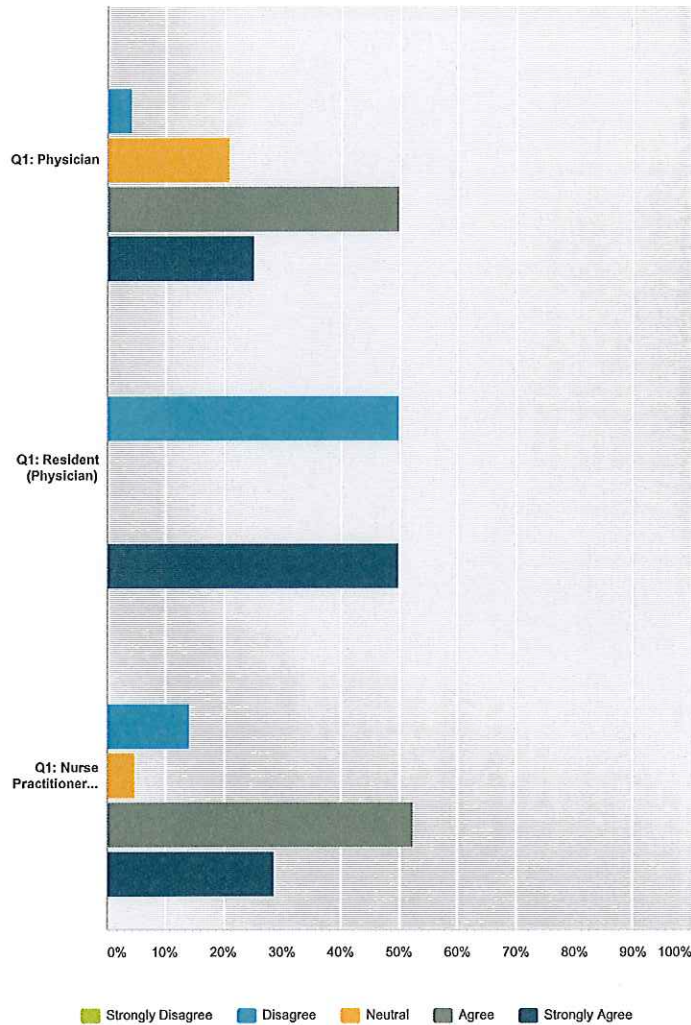


	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Q1: Physician	0.00% 0	12.50% 3	8.33% 2	54.17% 13	25.00% 6	24
Q1: Resident (Physician)	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	2
Q1: Nurse Practitioner or Physicians Assistant	0.00% 0	9.09% 2	9.09% 2	50.00% 11	31.82% 7	22
Total Respondents	0	5	4	25	14	48

Idaho Provider Satisfaction Survey, December 2014

Q4 I look forward to coming to work each day.

Answered: 47 Skipped: 1

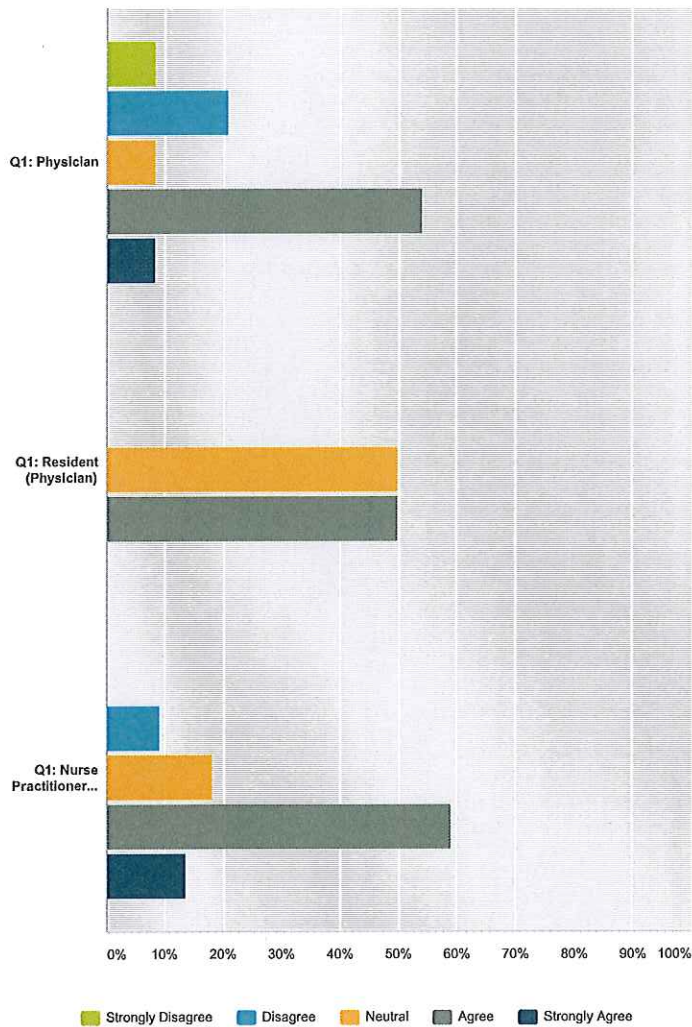


	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Q1: Physician	0.00% 0	4.17% 1	20.83% 5	50.00% 12	25.00% 6	24
Q1: Resident (Physician)	0.00% 0	50.00% 1	0.00% 0	0.00% 0	50.00% 1	2
Q1: Nurse Practitioner or Physicians Assistant	0.00% 0	14.29% 3	4.76% 1	52.38% 11	28.57% 6	21
Total Respondents	0	5	6	23	13	47

Idaho Provider Satisfaction Survey, December 2014

Q5 I am able to practice medicine as I envisioned when I finished my training.

Answered: 48 Skipped: 0

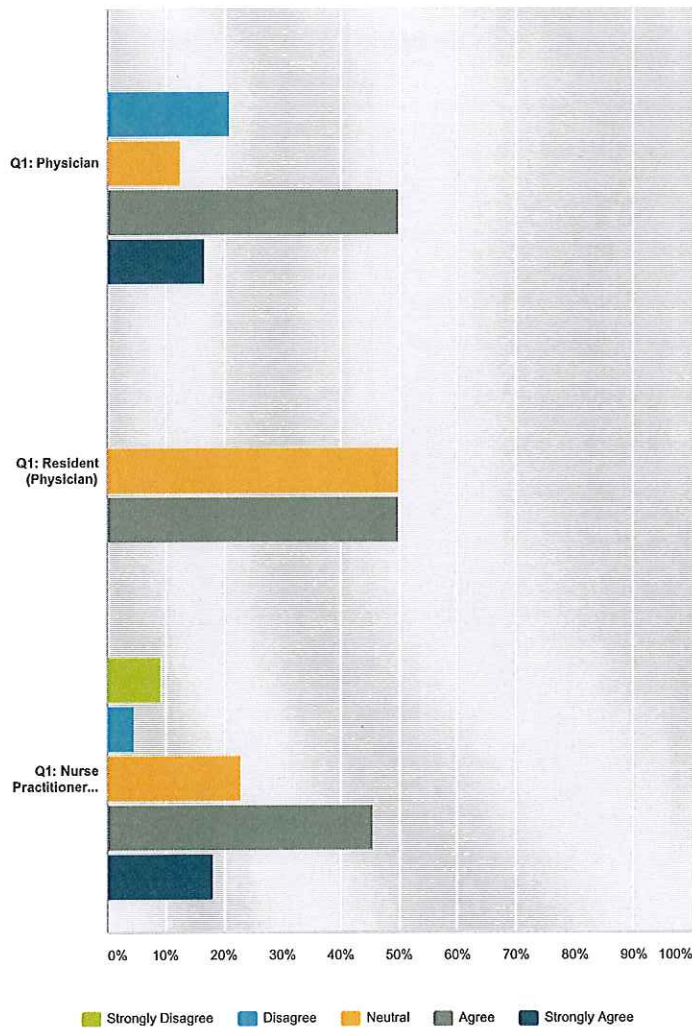


	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Q1: Physician	8.33% 2	20.83% 5	8.33% 2	54.17% 13	8.33% 2	24
Q1: Resident (Physician)	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2
Q1: Nurse Practitioner or Physicians Assistant	0.00% 0	9.09% 2	18.18% 4	59.09% 13	13.64% 3	22
Total Respondents	2	7	7	27	5	48

Idaho Provider Satisfaction Survey, December 2014

Q6 I am paid fairly for the work that I do.

Answered: 48 Skipped: 0

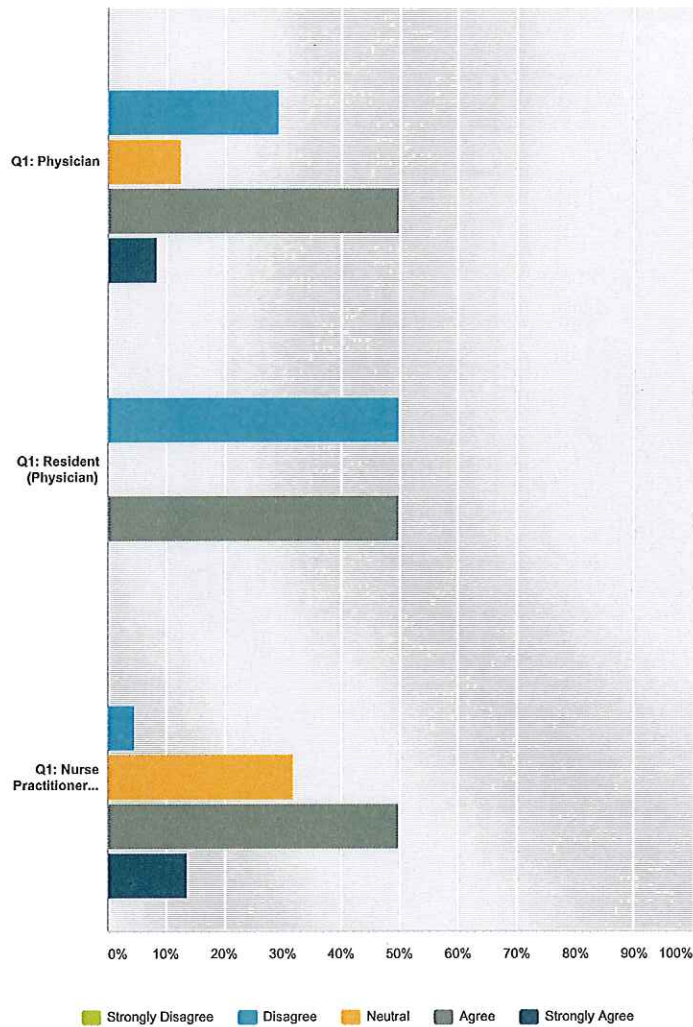


	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Q1: Physician	0.00% 0	20.83% 5	12.50% 3	50.00% 12	16.67% 4	24
Q1: Resident (Physician)	0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	2
Q1: Nurse Practitioner or Physicians Assistant	9.09% 2	4.55% 1	22.73% 5	45.45% 10	18.18% 4	22
Total Respondents	2	6	9	23	8	48

Idaho Provider Satisfaction Survey, December 2014

Q7 My current work-life balance is what I had envisioned.

Answered: 48 Skipped: 0

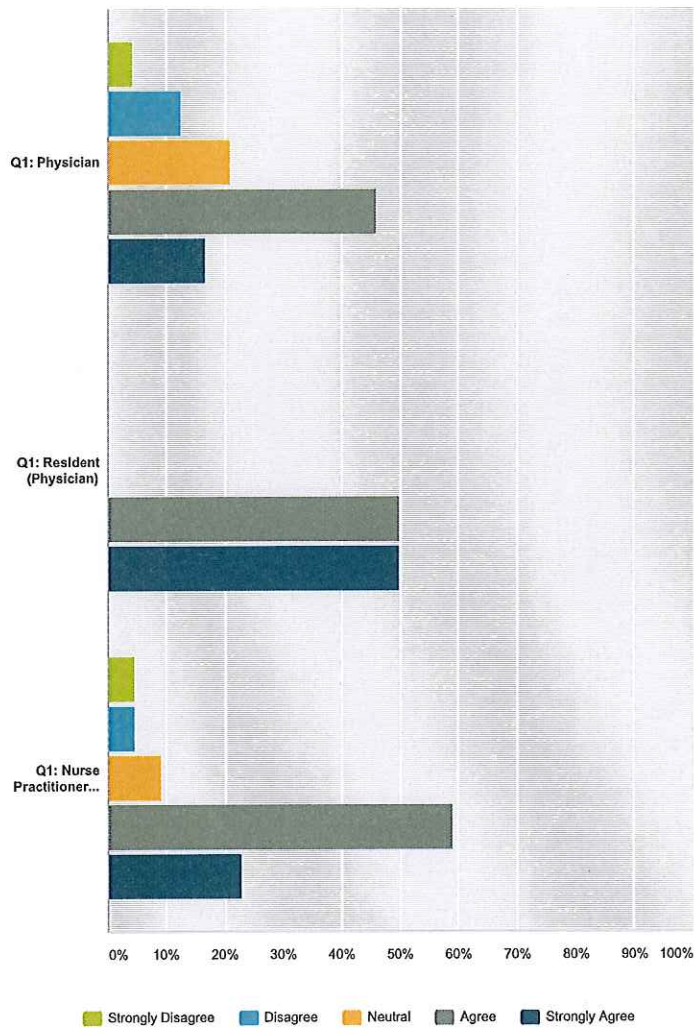


	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Q1: Physician	0.00% 0	29.17% 7	12.50% 3	50.00% 12	8.33% 2	24
Q1: Resident (Physician)	0.00% 0	50.00% 1	0.00% 0	50.00% 1	0.00% 0	2
Q1: Nurse Practitioner or Physicians Assistant	0.00% 0	4.55% 1	31.82% 7	50.00% 11	13.64% 3	22
Total Respondents	0	9	10	24	5	48

Idaho Provider Satisfaction Survey, December 2014

Q8 I have adequate clinical and clerical support while performing my job functions and taking care of patients.

Answered: 48 Skipped: 0

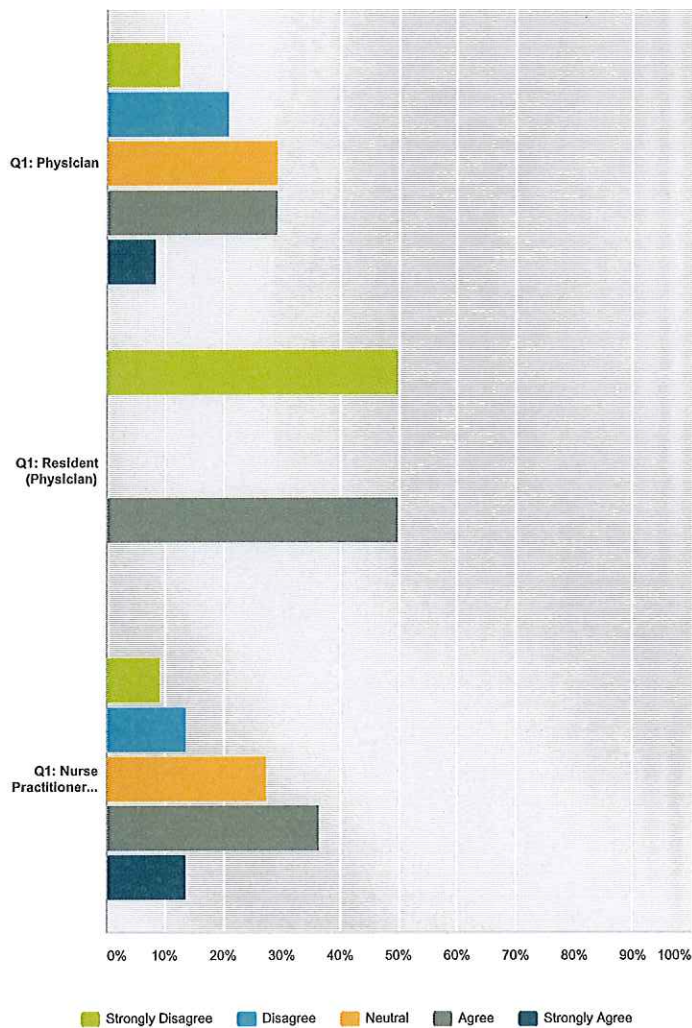


	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Q1: Physician	4.17% 1	12.50% 3	20.83% 5	45.83% 11	16.67% 4	24
Q1: Resident (Physician)	0.00% 0	0.00% 0	0.00% 0	50.00% 1	50.00% 1	2
Q1: Nurse Practitioner or Physicians Assistant	4.55% 1	4.55% 1	9.09% 2	59.09% 13	22.73% 5	22
Total Respondents	2	4	7	25	10	48

Idaho Provider Satisfaction Survey, December 2014

Q9 Using an EHR (electronic health record) has improved my ability to provide high quality care to my patients.

Answered: 48 Skipped: 0

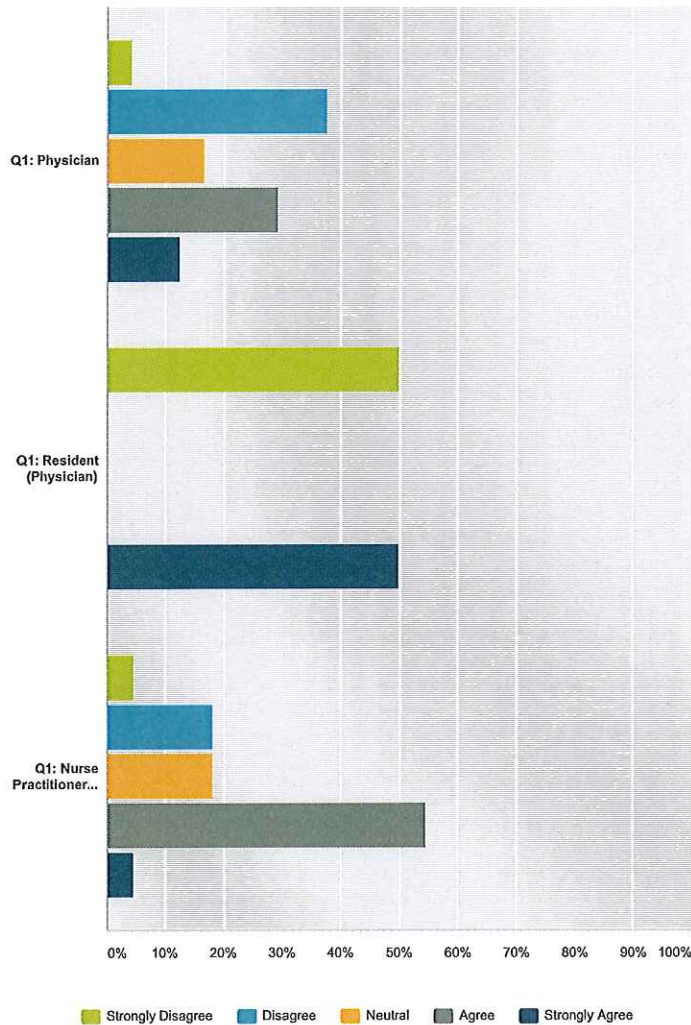


	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Q1: Physician	12.50% 3	20.83% 5	29.17% 7	29.17% 7	8.33% 2	24
Q1: Resident (Physician)	50.00% 1	0.00% 0	0.00% 0	50.00% 1	0.00% 0	2
Q1: Nurse Practitioner or Physicians Assistant	9.09% 2	13.64% 3	27.27% 6	36.36% 8	13.64% 3	22
Total Respondents	6	8	13	16	5	48

Idaho Provider Satisfaction Survey, December 2014

Q10 I think the benefits of adopting an EHR have outweighed the challenges.

Answered: 48 Skipped: 0



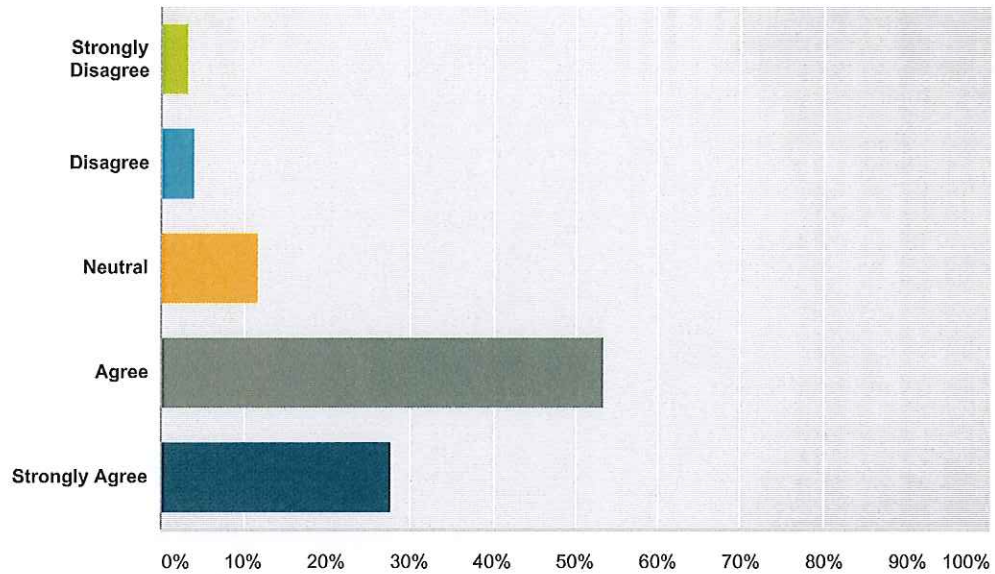
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Q1: Physician	4.17% 1	37.50% 9	16.67% 4	29.17% 7	12.50% 3	24
Q1: Resident (Physician)	50.00% 1	0.00% 0	0.00% 0	0.00% 0	50.00% 1	2
Q1: Nurse Practitioner or Physicians Assistant	4.55% 1	18.18% 4	18.18% 4	54.55% 12	4.55% 1	22
Total Respondents	3	13	8	19	5	48

Appendix C: Aggregated Results of Staff Satisfaction Survey

Individually Identifying Respondent Information Omitted

Q2 I have the tools and resources needed to perform my job.

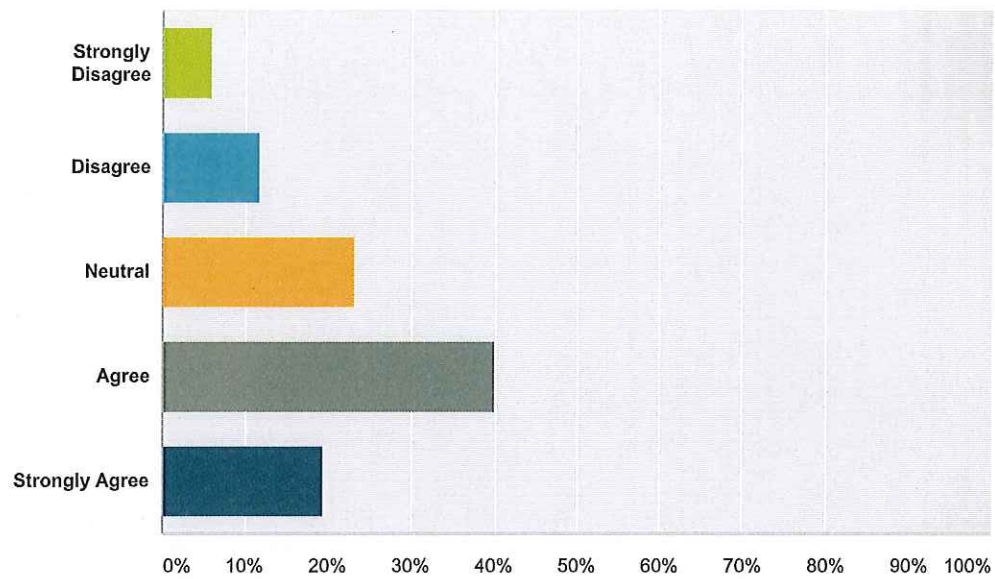
Answered: 155 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	3.23%	5
Disagree	3.87%	6
Neutral	11.61%	18
Agree	53.55%	83
Strongly Agree	27.74%	43
Total		155

Q3 I have opportunities to grow in my job.

Answered: 155 Skipped: 0

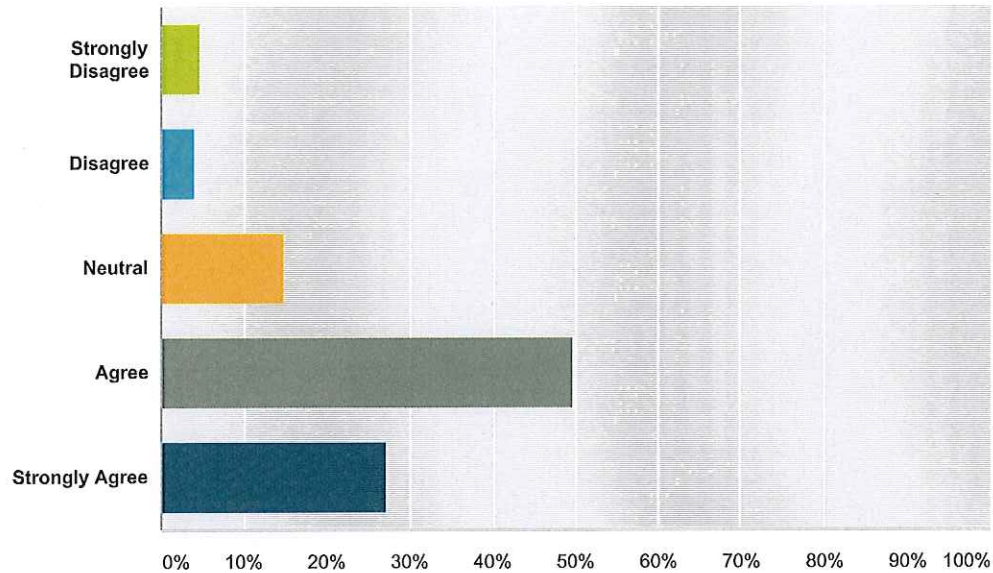


Answer Choices	Responses	
Strongly Disagree	5.81%	9
Disagree	11.61%	18
Neutral	23.23%	36
Agree	40.00%	62
Strongly Agree	19.35%	30
Total		155

Idaho Staff Satisfaction Survey, December 2014

Q4 I look forward to coming to work each day.

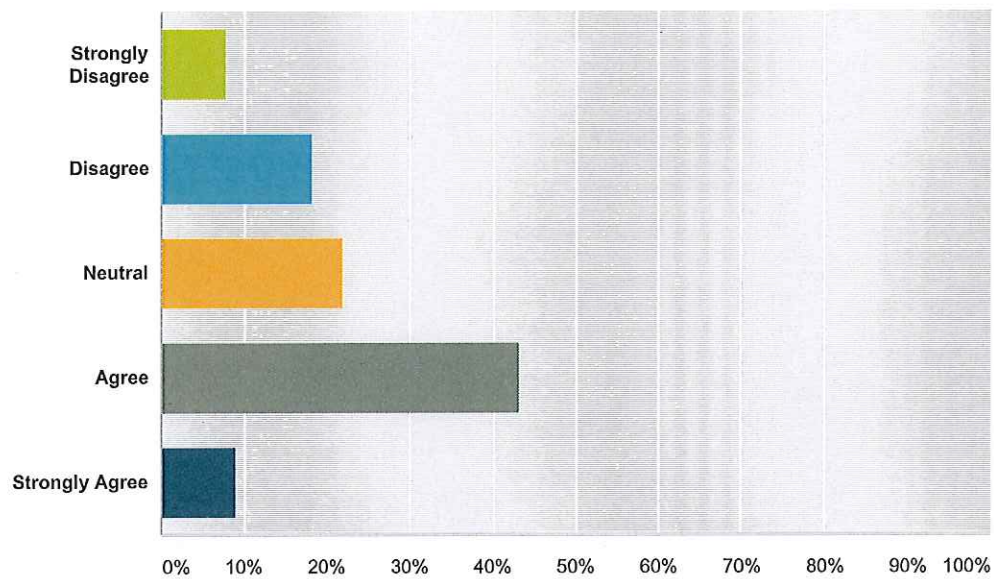
Answered: 155 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	4.52%	7
Disagree	3.87%	6
Neutral	14.84%	23
Agree	49.68%	77
Strongly Agree	27.10%	42
Total		155

Q5 I am paid fairly for the work that I do.

Answered: 155 Skipped: 0

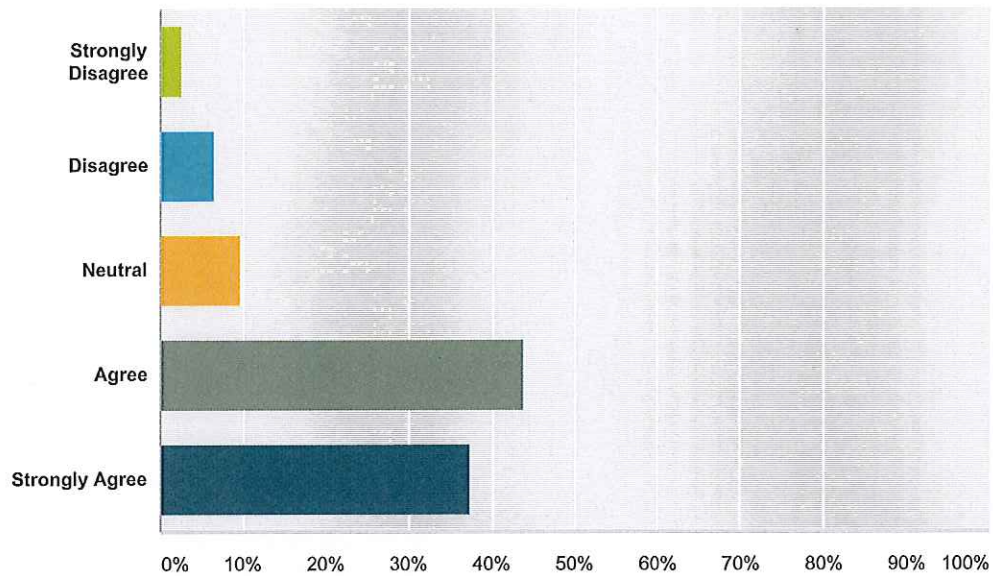


Answer Choices	Responses	
Strongly Disagree	7.74%	12
Disagree	18.06%	28
Neutral	21.94%	34
Agree	43.23%	67
Strongly Agree	9.03%	14
Total		155

Idaho Staff Satisfaction Survey, December 2014

Q6 I work with a supportive team.

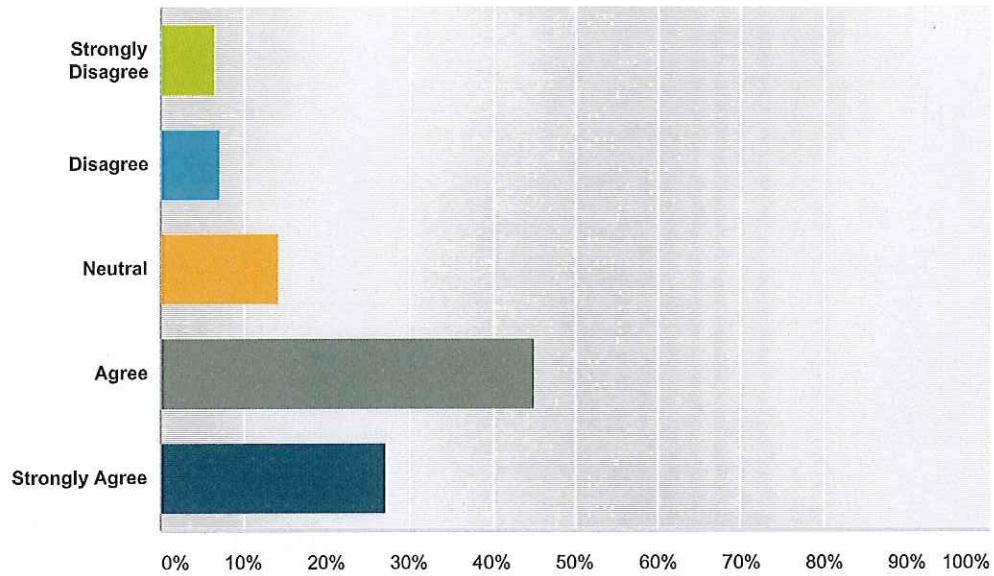
Answered: 155 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	2.58%	4
Disagree	6.45%	10
Neutral	9.68%	15
Agree	43.87%	68
Strongly Agree	37.42%	58
Total		155

Q7 I can tell my boss what I think.

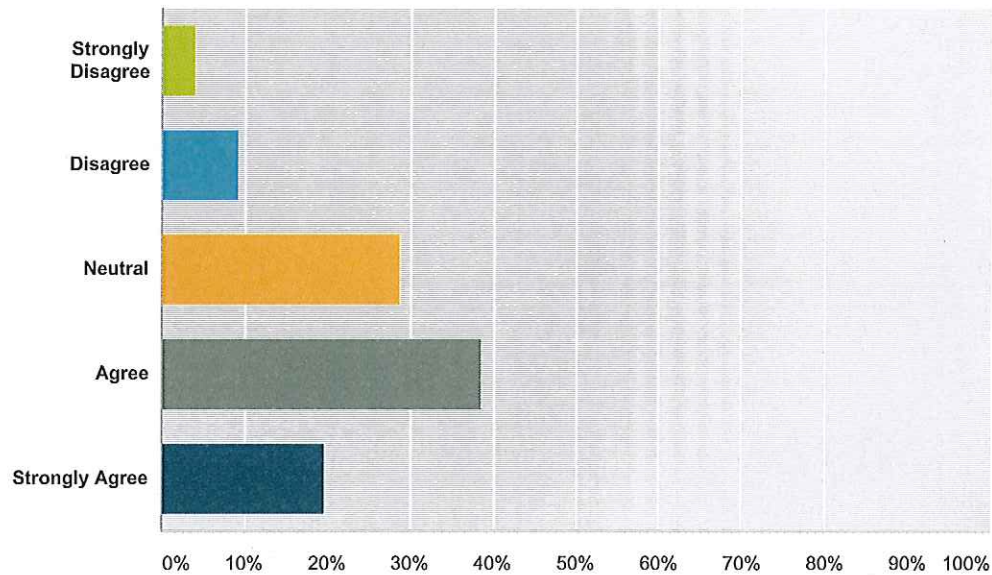
Answered: 155 Skipped: 0



Answer Choices	Responses	
Strongly Disagree	6.45%	10
Disagree	7.10%	11
Neutral	14.19%	22
Agree	45.16%	70
Strongly Agree	27.10%	42
Total		155

Q8 My ideas and suggestions are being considered, as part of the practice's transition to being a patient-centered medical home.

Answered: 153 Skipped: 2



Answer Choices	Responses	
Strongly Disagree	3.92%	6
Disagree	9.15%	14
Neutral	28.76%	44
Agree	38.56%	59
Strongly Agree	19.61%	30
Total		153

Appendix D: Practice Trait Variables Analyzed

These are the factors identified as variables within the practices participating in the project that were included within this review.

1. Region
 - a. 1-7
2. Payer Blend
 - a. Medicaid / Pacific Source
 - b. Medicaid / Regence
 - c. Medicaid / Blue Cross
3. Ownership
 - a. Corporate
 - b. Private
 - c. Residency
4. Staff Composition
 - a. # MD/DO's
 - b. # Physician Extenders (NP/PA)
 - c. # additional staff
5. Staffing Ratio
6. Patient Portal in Use
 - a. Yes/No
7. Received Health Information Technology Funds
 - a. Yes/No
8. Idaho Health Data Exchange Participant
 - a. Yes/No
9. NCQA Recognized
 - a. No
 - b. Applied
 - c. Recognized
10. Federally Qualified Health Center
 - a. Yes/No
11. Designated Rural Health Clinic
 - a. Yes/No
12. Electronic Medical Record in User
 - a. Which EMR
13. PCMH-A Scores (Baseline and Change During Project)
 - a. Empanelment
 - b. Continuous Based Healing Relationship
 - c. Patient Centered Interaction
 - d. Engaged Leadership
 - e. QI Strategy
 - f. Enhanced Access
 - g. Care Coordination
 - h. Organized Evidence Based Care
 - i. Total Score
14. PCDC Scores (Baseline and Change During Project)

- a. Domain 1
- b. Domain 2
- c. Domain 3
- d. Domain 4
- e. Domain 5
- f. Domain 6
- g. Total Score

Appendix E: Self-Reported Measures Analyzed

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Clinical Quality	Diabetes: Hemoglobin A1c Testing Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.	One or more HbA1c tests performed during the measurement year.	Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type I or II) Exclusions apply. Pharmacy and diagnosis codes are provided	NCQA NQF#57
Clinical Quality	Diabetes: HBA1c Poor Control The percentage of patients 18-75 years of age with diabetes (Type I or II) who had HbA1c >9.0	Laboratory tests results: HBA1c test. Most recent value >9.0	Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type I or II) Exclusions apply. Pharmacy and diagnosis codes are provided	NCQA NQF#59

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Clinical Quality	Controlling High Blood Pressure The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year	Physical exam finding diastolic blood pressure < 90 mmHg, and systolic blood pressure < 140 mmHg, during most recent outpatient encounter.	Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of hypertension during the first six months of the measurement year.	NCQA NQF#18
Clinical Quality	Hypertension: Blood Pressure Measurement Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.	Physical Exam finding systolic and diastolic blood pressure	Patients with active hypertension who are 18 or older	AMA-PCPI NQF# 13

Clinical Quality	<p>Anti-depressant medication management: (a) Effective Acute Phase Treatment (b) Effective Continuation Phase Treatment</p>	<p>Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSP (inclusive) The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114 day period. Gaps can include either washout period gaps to change medications or treatment gaps to refill the same medication</p> <p>Regardless of the number of gaps, there may be no more than 30 gap days, Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days)</p>	<p>Total number of patients 12 and older who were diagnosed with a new episode of major depression and treated with an antidepressant medication</p>	NCQA
	<p>The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.</p>	<p>Effective Continuation Phase Treatment at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSP (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 213-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.</p> <p>Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25</p>		NQF#105

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Clinical Quality	Asthma Assessment Percentage of patients aged 5 through 50 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms	Symptom assessed or active: asthma daytime symptoms quantified Symptom assessed or active: asthma nighttime symptoms quantified.	Patients aged 5 to 50 years with diagnosis of active asthma.	AMA-PCPI NQF#1

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Clinical Quality	Asthma Pharmacologic Therapy Percentage of patient aged 5 through 50 years with a diagnosis of mild, moderate or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment	Number of patients with medication order or medication active: Corticosteroid, inhaled or alternative asthma medication	Patient aged 5 through 50 years with a diagnosis of active asthma or asthma persistent, and at least two office encounters	AMA_PCPI NQF#47

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Clinical Quality	<p>Management Plan for People with Asthma</p> <p>Percentage of patients for whom there is documentation with a written asthma management plan was provided either to the patient or the patient's caregiver OR, at a minimum, specific written instruction on under what conditions the patient's doctor should be contacted or the patient should go to the emergency room.</p>	<p>Patients for whom there is documentation, at any time during the abstraction period that a written asthma management plan was provided either to the patient or the patient's caregiver OR at a minimum specific written instruction on under what conditions the patient's doctor should be contacted or the patient should go to the emergency room.</p>	<p>Total number of patients who had at least two separate ambulatory visits to your practice site for asthma during the time period January through December</p>	<p>I PRO</p> <p>NQF#25</p>

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Preventative Care and Screening	Weight Assessment and Counseling for Children and Adolescents			
	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or OB/GYN and who had evidence of body mass index(BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	Physical exam finding BMI percentile;	Children 3-17 years of age with at least one outpatient visit with a PCP or OB/GYN	NCQA
		Communication to patient counseling for nutrition;		NQF#24
		Communication to the patient counseling for physical activity.		

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Preventative Care and Screening	<p>Well-Child visits in the Third, Fifth and Sixths years of life</p> <p>Percentage of patients 3-6 years of age who received one or more well-child visit with a PCP during the measurement year.</p>	Received one or more well-child visit with a PCP during the measurement year.	Patients 3-6 years of age	<p>NCQA</p> <p>NQF#1516</p>

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Preventative Care and Screening	Annual Risky Behavior Assessment or Counseling from age 12-18 Percentage of children aged 12-18 with documentation of assessment or counseling for risky behavior, Four rates are reported: Risk Assessment or counseling for Alcohol use, Risk Assessment or counseling for Tobacco use, Risk Assessment or counseling for Other Substance Abuse, Risk Assessment or counseling for Sexual Activity	Documentation of assessment or counseling for risky behavior during the past 12 months,. Four rates are reported: Risk Assessment or counseling for Alcohol use, Risk Assessment or counseling for Tobacco use, Risk Assessment or counseling for Other Substance Abuse, Risk Assessment or counseling for Sexual Activity	Total number of patients between the ages of 12-18	NCQA <i>Adapted</i> NQF#1507 NQF#1406

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Preventative Care and Screening	Tobacco Use: Screening and Cessation Intervention Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user	Patients who were screened for tobacco use * at least once during the two-year measurement period AND who received tobacco cessation counseling intervention ** if identified as a tobacco user	All patients aged 18 years and older who were seen twice for any visits of who had at least one preventive care visit during the two-year measurement period	NCQA NQF#28

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Preventative Care and Screening	<p>Adult Weight Screening and Follow-up</p> <p>Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit.</p> <p>Normal Parameters: Age 65 year and older BMI \geq to 23 and <30</p> <p>Age 18-64 years BMI \leq to 18.5 and <25</p>	Patients with a BMI calculated within the past six months or during the current visit and a follow-up plan documented within the past six months or during the current visit if the BMI is outside of the normal parameters	Patients age 18 an older who had one or more encounter office visits.	<p>QIP</p> <p>NQF#421</p>

Measure Type	Measure Name (Bolded) & Description	Numerator Statement	Denominator Statement	Measure Source
Preventative Care and Screening	Adult BMI Assessment Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.	BMI documented during the measurement year or the year prior to the measurement year.	Members 19-74 years of age who had an outpatient visit	Medicaid Adult Core Set HEDIS NCQA
Practice Transformation for PCMH <i>Enhance Access and Continuity</i>	Third next available appointment Measuring how long it takes to get patients into the schedule based on the third next available appointment	The length of time from when a patient contacts the practice to request an appointment, to the third next available appointment on his/her clinician's schedule. The practice may measure availability for a variety of appointment types including new patient physicals, routine exams and return-visit exams		NCQA Standard 1, Element A, Factor 1

